STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155512	A. BUILDING _____ B. WING _____	R 04/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE SACRED HEART HOME	**515 N MAIN ST AVILLA, IN 46710**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on March 11, 2014.

Survey date: April 22, 2014
Facility number: 000404
Provider number: 155512
AIM number: 100290810

Survey team:
Carol Miller, RN, TC
Diane Nilson, RN
Timothy Long, RN
Rick Blain, RN

Census bed type:
SNF: 7
SNF/NF: 98
Residential: 8
Total: 113

Census Payor type:
Medicare: 1
Medicaid: 78
Other: 34
Total: 113

Residential sample: 5

Presence Sacred Heart Home was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the Recertification and State Licensure Survey.

Quality Review completed on April 24, 2014, by Brenda Meredith, R.N.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE